Duty of Candour Annual Report

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of our responsibilities, we must produce an annual report to provide a summary of the number of times we have trigger duty of Candour within our service.

Name & address of service:	Ardgowan Hospice 12 Nelson Street Greenock PA15 1TS	
Date of report:	06 May 2019	
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively? How have you done this?	Ardgowan Hospice released a Duty of Candour Policy in May 2018. Staff were invited and attended awareness sessions on the Duty of Candour providing them with an insight, understanding and discussion around the policy and the background to it. The policy is accessible for all staff from our electronic policy folder. The policy will be included in our mandatory staff training programme. There is a Duty of Candour flow chart to assist staff in the process of decision making and reporting of any potential Duty of Candour Incident. Our Clinical incident reporting form now has a Duty of Candour section for staff to complete. This reminds staff to consider if a Duty of Candour incident has occurred. All staff have completed the Duty of Candour Learnpro module.	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	

How many times has the service implemented the duty of candour procedure this financial year?	
Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions)	Number of times this has happened (April 2018 - March 2019)
A person died	
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
A person's treatment increased	
The structure of a person's body changed	
A person's life expectancy shortened	
A person's sensory, motor or intellectual functions was impaired for 28 days or more	
A person experienced pain or psychological harm for 28 days or more	
A person needed health treatment in order to prevent them dying	
A person needing health treatment in order to prevent other injuries as listed above	
Total	**0**

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result is any under or over reporting of duty of candour?	Not Applicable
What lessons did you learn?	
What learning & improvements have been put in place as a result?	
Did this result is a change / update to your duty of candour policy / procedure?	
How did you share lessons learned and who with?	
Could any further improvements be made?	
What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	We have a policy which provides clear written guidance and have provided staff training on the Duty of Candour. Our Senior Management Team can support the staff with 24 hour 7 days a week support in the event this is required.
What support do you have available for people involved in invoking the procedure and those who might be affected?	Staff will be supported immediately by the most senior member of staff on duty and the Director of Care or Consultant will follow up and provide further support where appropriate. We would organise a team reflective practice session for all staff, in particular those involved in the incident and invite counselling support team to attend. If required staff have access to external support systems on request. This can be anonymously.
Please note anything else that you feel may be applicable to report.	